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The National Association of Public Hospitals and Health Systems
The U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on Medicaid Reform

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The National Association of Public Hospitals and Health Systems (NAPH) is grateful for this opportunity to submit a statement for the record to the House Energy and Commerce Committee Subcommittee on Health on the subject of Medicaid reform.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide healthcare services to all individuals, regardless of insurance status or ability to pay. More than 61 percent of the patients served by NAPH members are either Medicaid recipients or patients without insurance. Medicare covers another 20 percent of the patients of NAPH members, who rely on governmental sources of financing for over 80% of their services.

Medicaid is as important to our nation's safety net hospitals as it is to the 44 million individuals it covers. Arguably, given the well-known gaps in Medicare benefits, Medicaid is our nation's most important and successful health care program. Medicaid covers 55% of all poor children (20% of all children in the nation) and pays for one third of all births. It is far and away the nation's largest purchaser of long term care services. It is also an essential lifeline for low-income elderly individuals and those who are blind and disabled. Indeed, any effort to reform Medicaid must start with the recognition that over two thirds of Medicaid spending today is devoted to the elderly, blind and disabled.

Medicaid is also a major source of essential financing for America's institutional health safety net. Forty percent of the net revenues of NAPH member hospitals are Medicaid revenues. In particular, the Medicaid Disproportionate Share Hospital (DSH) program is the cornerstone of financial support for hospital services to all low-income Americans, including the rising numbers of uninsured. In 2000, while constituting less than 9 percent of total Medicaid spending, Medicaid DSH payments covered 28 percent of the otherwise unreimbursed costs incurred by NAPH members in treating the uninsured and underinsured. In this regard, Medicaid must be considered a true partner of state and local governments, whose payments and subsidies account for another 39 percent of such unreimbursed costs. Medicaid reimbursement is also important to Federally Qualified Health Centers (FQHCs), which provide a significant amount of services to Medicaid patients and patients without insurance.

Yet Medicaid is not without problems. Medicaid's funding and benefits (including DSH payments) are spread unevenly across the states. Eligibility and covered services vary widely as well. At the same time, Medicaid has become the fastest growing part of many state budgets.

This latter fact has been especially problematic for many states that are confronted with reduced revenues and fiscal crisis as a result of the current economic downturn. First and foremost, Medicaid reforms should not result in further pressure on states that are already facing such crises.

These and other concerns about Medicaid can and should be addressed by the Congress, and NAPH is willing to work with this Committee, the Administration and all other stakeholders to address needed reforms. At the same time, it is essential that any effort to reform Medicaid acknowledge and build on (not seek to dismantle) the program's considerable strengths. In that regard, NAPH strongly urges the Congress to be guided by several important principles in addressing future Medicaid reforms. Please note that NAPH is aware of, and has reviewed the limited information available thus far about, the Administration's new proposal for Medicaid reform. We do not believe the Administration's proposal meets the principles described below, based on the proposal as we understand it. We intend these principles to apply to any major Medicaid reforms that may be considered or introduced in the future, not just to the Administration proposal.

Protect the Guarantee of Coverage to Medicaid Recipients. Medicaid reform efforts should not result in reducing or eliminating the entitlement of our most vulnerable populations to coverage. A federally enforceable entitlement to coverage is the foundation of Medicaid's success. Eroding that entitlement for current recipients would be a major step backwards for a country that must already confront the dilemma of over 41 million uninsured residents.

Expand Coverage Beyond Current Levels. Health care coverage is recognized as the primary way to provide access to needed health services for low-income populations. Medicaid reform should not be enacted in a vacuum. Rather, Medicaid reforms must be carefully tied to renewed efforts to expand coverage, as one important tool in an anticipated combination of public program improvements and private sector initiatives. Moreover, it is important that the impact of Medicaid reforms on all populations among the uninsured (including, e.g., legal and illegal immigrants, persons with AIDS, etc.) be taken into account in crafting effective reforms.

Ensure the Availability of Comprehensive Benefits to Covered Individuals. As we understand it, the Administration's proposal would require coverage of the mandatory Medicaid population, but allow states absolute flexibility to decide which non-mandatory populations and health care services will be covered in the future. Of particular concern to NAPH is the erosion of coverage of optional services such as prescription drugs for the poor, elderly, and disabled. To the extent Medicaid reform permits states to limit essential services to enrollees, it will merely shift even more of the burden for providing those services to safety net providers, at a time when the health care safety net is already in crisis. Rising numbers of uninsured, worker shortages, increased drug costs, and expanded community-wide responsibilities (including an expanded role as first responder in the event of chemical and biological terrorism) are increasing costs. At the same time, current sources of federal, state and local funding are being eroded. Nearly half of NAPH members had negative margins in 2000 (the latest year for which data are available), up from one-third with negative operating margins five years earlier.

Strengthen Safety Net Providers. Particularly at a time when the number of Medicaid enrollees and uninsured are increasing, further reducing or eliminating direct payments to safety net hospitals, like Medicaid DSH, could rapidly destroy our nation's fragile system for providing care to the uninsured. Medicaid DSH is one of the most important funding sources for many hospitals – often the major (if not only) reason they can continue serving the uninsured and providing essential community-wide services like trauma care. The Institute of Medicine (IOM) in its March 2000 report recommended that "Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve."

Future Medicaid Spending Must Be Based on Need, Not an Arbitrary Base Year. The Administration's proposal caps future federal Medicaid spending at FY 2002 levels, updated yearly by a non-specified trend factor. The required state maintenance of effort would also be tied to the FY 2002 base year amounts, with annual updates. Such a cap in effect constitutes little more than "price controls" at the state level. It is completely arbitrary and does not reflect one of the great strengths of Medicaid, which has been its ability to respond to changing needs. While it is true that health costs have been rising rapidly in recent years, those costs are largely beyond the control of states or providers, who would instead be forced to respond to arbitrary caps through reduced eligibility or coverage.

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Whatever the direction this Committee chooses to take on Medicaid reform in the long run, there are several essential steps that need to be taken in the very near future, to preserve and protect both vulnerable patients and the providers that serve them. Those steps include:

Provide Urgent Fiscal Relief to the States. States are facing severe budget problems caused by the current economic crisis. Many states clearly need help to maintain their Medicaid programs while the economy recovers. Congress and this Committee should pass some sort of fiscal relief to states to help alleviate pressure on state Medicaid budgets.

Fix the Medicaid "DSH Cliff" Problem Created by the Balanced Budget Act of 1997. Congress and the Committee should move immediately to enact the Access to Hospitals Act of 2003 (H.R. 328) introduced by Representatives Ed Whitfield (R-KY) and Diana DeGette (D-CO). This bipartisan legislation would eliminate a drastic and untenable reduction in federal Medicaid DSH funding in the current fiscal year. This "cliff" has a potentially devastating impact on safety net hospitals and patients in many states, at a time when the number of uninsured is increasing and other funding sources are eroding. Last year, this Committee recognized the desperate need for Medicaid DSH relief in this fiscal year, including it in legislation passed by this Committee. We encourage the Committee to act swiftly and support efforts this year to fix this outstanding problem.

Provide a Modest Increase in DSH Funding for "Low-DSH" States. A significant inequity in the allocation of DSH funding among states must also be corrected to permit states with extremely low DSH allotments to increase DSH payments to the minimal level of 3 percent of state Medicaid spending. While this does not bring such states near the national average of nearly 6 percent, such an increase is both essential and equitable for affected states. Congress

and this Committee should support legislation like H.R. 1604 introduced last Congress by Representative Heather Wilson (R-NM) to increase the federal Medicaid allotment for such states. We understand Representative Wilson and Representative Jerry Kleczka (D-WI) will introduce similar legislation shortly in this Congress.

Allow Section 340B Hospitals to Negotiate Better Prices for Inpatient Drugs. Drug prices are one of the major issues that face all providers, including public hospitals. Extending the best price exemptions to inpatient prices charged to 340B hospitals would allow safety net hospitals to negotiate better discounts on inpatient pharmaceuticals. The Congressional Budget Office has determined that this change would have no cost to the government. We encourage the Committee to clarify the law as quickly as possible.

Increase the Medicaid Rebate and 340B Drug Discount. Congress and this Committee should increase the Medicaid rebate and ensure that 340B providers have access to the same discounts as the Medicaid program to save money for federal, state, and local governments struggling to ensure pharmaceutical coverage to vulnerable populations.

Extend the Availability of SCHIP Allotments. Congress and this Committee should extend the availability of SCHIP allotments in order to allow states additional opportunities to use these funds to expand coverage.

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NAPH appreciates the opportunity to share our observations and concerns. We urge the Committee to take action on these important issues. We look forward to working with you further to develop legislative solutions to the problems confronting our nation's poor and uninsured and the safety net providers that serve them.